REVISION DATES: 12/30/2015; 04/26/2013; 05/31/2012

GENERAL INFORMATION

Indian Health Service (IHS) and tribal providers should exhaust all authorized processing procedures before filing a claim dispute with the AHCCCS Office of Administrative Legal Services (OALS). It is recommended that providers follow these guidelines before filing a claim dispute.

If the provider has not received a Remittance Advice identifying the status of the claim, the provider should utilize AHCCCS on-line at http://www.azahcccs.gov to view the claim's status to determine whether the claim has been received and processed. Once at the Home Page, click on the icon for Plans/Providers (blue tab at the top of the screen). A link on the Provider website (AHCCCS Online) allows providers to create an account so that they can check the status of their claims.

Providers should allow 14 days following claim submission before inquiring about a claim.

However, providers should inquire well before 6 months from the date of service because of the clean claim time frame and the time frame for filing a claim dispute.

If a claim is pending in the AHCCCS claims processing system, a claim dispute will not be investigated until the claim is paid or denied. A delay in processing a claim by the AHCCCS Administration *may* be cause for OALS to entertain a claim dispute on a pended claim provided all claim dispute deadlines are met.

If the provider has exhausted all authorized processing procedures and still has a disputed claim, the provider has the right to file a claim dispute with OALS.

TIME LIMITS FOR FILING

The provider must institute any claim dispute challenging the claim denial or adjudication within 12 months from the ending date of service; the date of the recipient's eligibility posting; or, for a hospital inpatient claim, within 12 months from the date of discharge, or within 60 days after the date of the denial of a timely claim submission, whichever is later. The date of receipt by OALS is considered the date the claim dispute is filed.

For a retro-eligibility claim, the provider must institute any claim dispute within 12 months from the date of the eligibility posting.

If action on a timely submitted, clean claim fewer than 60 days before the expiration of the 12-month deadline or after the 12-month deadline has passed, the provider will be allowed 60 days from the date of the adverse action to file a claim dispute with OALS. The date of the "adverse action" is the status date for the claim as printed on the Remittance Advice.

Example:

03/06/2013 Date of service
05/15/2013 Initial claim denied by AHCCCS
12/16/2013 Date of resubmission of denied claim
03/04/2014 Claim is denied by AHCCCS (adverse action date)
03/06/2014 12-month grievance/clean claim deadline
05/05/2014 Special 60-day claim dispute deadline

Because the denial of the resubmitted claim was less than 60 days from the 12-month deadline, the provider is given 60 days from the date of the adverse action (03/04/2014) to file a claim dispute.

CLAIM DISPUTE PROCESS

A claim dispute must be submitted in writing. Mail the claim dispute to:

AHCCCS Office of Administrative Legal Services
Mail Drop 6200
P.O. Box 25520
Phoenix, AZ 85002

The claim dispute also may be hand delivered to:

AHCCCS Office of Administrative Legal Services
701 E. Jefferson Street, 3rd Floor
Phoenix, AZ 85034

Providers also may submit a claim dispute via fax at (602) 253-9115.

The claim dispute must state in detail the factual and legal basis of the claims dispute and the relief requested (e.g., payment, specific claim denial, quick pay discount). Claim

disputes lacking specificity may be denied. Include any documents which support the facts of the case.

Upon receipt of a claim dispute, OALS will send a letter of acknowledgment to the provider. This letter should be retained for reference.

The provider will receive a written Notice of Decision from OALS which will approve, deny, or partially approve the disputed claim.

If an informal decision is issued in writing, the provider will be advised that they may appeal the decision and request a state fair hearing. The written request must be received by OALS no later than 30 days from the date of receipt of the written Notice. If the 30th day falls on a Saturday, Sunday, or legal holiday, the request for hearing must be received no later than the next working day.

Claim Dispute Process for claims with Behavioral Health Diagnosis

All disputes related to payment of claims with a behavioral health diagnosis, **except those from IHS or 638 facilities,** must be filed with the **Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS). Claim disputes involving IHS or 638 facilities must be filed with the AHCCCS Administration.** All providers are required to file claim disputes no later than 12 months from the date of service, 12 months from the date of eligibility posting, or within 60 days from the date of denial of a timely submitted claim, whichever is later. This means that ADHS/DBHS, or the AHCCCS Administration for purposes of IHS/638 facility claim disputes, must ***receive*** the claim dispute within the timeframes listed above. The date of receipt by OALS is considered the date the claim dispute is filed.

1. For claims **not involving IHS or 638 facilities,** the claim dispute must be filed with ADHS/DBHS at the following address:

ADHS/DBHS Office of Grievance and Appeals
c/o AHCCCS Administration
Office of Administrative Legal Services
701 E. Jefferson Street Mail Drop 6200
Phoenix, AZ 85034

2. For claim disputes **related to services provided by IHS or 638 facilities,** the claim dispute must be filed with the AHCCCS Administration at the address below:

AHCCCS Office of Administrative Legal Services
Mail Drop 6200
P.O. Box 25520
Phoenix, AZ 85002

APPROVING A CLAIM DISPUTE

If OALS determines that the original claim denial was in error, the claim is forwarded from OALS directly to the AHCCCS Claims Unit for reprocessing. Do ***not*** resubmit the claim to AHCCCS with a copy of the written Notice of Decision from OALS.

Approving a claim dispute does not constitute a guarantee of payment nor does it constitute a waiver of all claim filing requirements and conditions because the claim may not be payable for other reasons. Claims are subject to all routine claims processing edits and audits. If the submitted claim contains errors, omissions, or does not have the required documentation, the claim may be denied or an edit may fail, even though the claim dispute has been approved for other reasons.

If the provider disagrees with the adjudication of the claim, the provider should contact the AHCCCS Claims Customer Service Unit at (602) 417-7670 or 1-800-794-6862. The provider must reference the claim dispute matter number and indicate that the claim was forwarded by OALS.

HEARING PROCESS

All AHCCCS hearings are conducted by the Arizona Office of Administrative Hearings, an independent state agency. An administrative law judge from the Office of Administrative Hearings will conduct the hearing, decide the facts, apply law, and make a recommendation to the AHCCCS Administration.

When a hearing is requested, the AHCCCS Administration will notify you in writing of a hearing date, time, and location.

Requests and motions concerning the case must be submitted in writing to the assigned administrative law judge. All requests and motions also must be copied to any other party and the AHCCCS Administration.

Requests to reschedule a hearing must be submitted in writing to the administrative law judge. All requests to conduct hearings telephonically must be submitted in writing to the Office of Administrative Hearings.

Subpoenas must be submitted to the Office of Administrative Hearings for the assigned administrative law judge's approval. Subpoena forms and instructions for completing the forms are available from the Office of Administrative Hearings.

The administrative law judge's recommendation will be forwarded to the AHCCCS director, who will issue a director's decision. A petition for a re-hearing must be submitted within 30 days of the director's decision. The director will determine whether to amend the decision or order a re-hearing.

Office of Administrative Hearings
1400 W. Washington Street
Suite 101
Phoenix, AZ 85007
Telephone: (602) 542-9826
Fax: (602) 542-9827
Website: www.azoah.com

DISPUTES NOT RELATED TO CLAIMS

Disputes unrelated to claims denial (e.g., enforcement of a policy, recoupment actions, or unfavorable decision by AHCCCS) must be filed in writing and received by the Office of Administrative Legal Services no later than 60 days after the date of the adverse action.

Any documents that support the facts of the case should be included. The dispute should state in detail the factual and legal basis, and the relief requested. Failure to do so may constitute cause for denial of the dispute.

If a written Notice of Decision is issued, you may submit a written hearing request as described earlier. Some cases may be referred directly for a hearing.

CLAIM DISPUTE SUBMISSION SUGGESTIONS

In recent years reimbursement for medical services has become increasingly more complex. The following are a few suggestions to help providers through the claim dispute process.

If a provider files a claim dispute for nonpayment but payment is made before a written Notice of Decision is received, the provider should submit a letter to withdraw the dispute.

Once the claim is paid, if the provider is dissatisfied with reimbursement, a claim dispute may then be filed within the required time frames.
Claim disputes for recipients enrolled in a health plan on the date of service in dispute must be filed with the health plan.

If a provider believes that the AHCCCS Claims Customer Service Unit provided erroneous information the claim dispute must specify the date and approximate time the call was made to AHCCCS and include the name of the AHCCCS Claims Customer Service Representative who provided the information.

Failure to provide the date and time of the call and the name of the AHCCCS Claims Customer Service Representative may result in denial of the claim dispute.
All claim disputes must be filed with specificity.

The request must state why the claim dispute is being filed and why the provider believes the claim was not processed properly.
Failure to do so may constitute cause for denial of the claim dispute.

DISPUTE AVOIDANCE

AHCCCS Claims Customer Service will assist providers with problem resolution and resubmission of fee-for-service claims. This unit can help providers avoid the claim dispute process. AHCCCS Claims Customer Service can be reached at (602) 417-7670 or 1-800-794-6862.

Claims Customer Service will also research claims that the provider believes were incorrectly processed and/or paid and provide clarification and explanation. (See Chapter 17, Correcting Claim Errors)

If the provider receives a Remittance Advice from AHCCCS and believes that a claim was denied inappropriately or paid incorrectly, contact Claims Customer Service as soon as possible. Be prepared to provide the Claims Customer Service representative with the following:

Your provider ID number

Recipient's AHCCCS ID number

Date(s) of service in question

Claim Reference Number (CRN)

Denial reason

Claims Customer Service will evaluate the claim data, the system processing of the claim, and all related provider and reference information and determine if the denial or payment was appropriate.

A Claims Customer Service representative will notify you of the action taken and the outcome for the claim in question. If the provider still believes the claim was incorrectly processed then the provider should file a claim dispute.

NOTE: This process does not take the place of the claim dispute procedure outlined in this chapter nor does it extend the grievance filing deadlines.

REVISION HISTORY

Date	Description of changes	Page(s)
12/30/2015	New chapter format Updated address for BH disputes not involving IHS or 638 providers	All 3
04/26/2013	Update by OALS; language/grammar corrections	All